Standard Life

Evidence of insurability

Administration department
P.O. Box 4002, Postal Station B
Montréal, Québec H3B 4M2

Administrative information (please print)

Policyholder name | Policy no. | Division no.

Participant surname | Given name(s) | Initial | Certificate no.

1. Why are you submitting evidence of insurability?

☐ Increase in insurance coverage in excess of maximum without evidence of insurability

☐ Late application for participation in group plan
Date of permanent full-time employment with present employer Y Y Y Y M M D D

☐ Application for optional life insurance — Total amount: Participant $ | Spouse $ | Children $

☐ Application for optional Accidental Death and Dismemberment insurance — Total amount: Participant $ | Spouse $ | Children $

☐ Late application for dependent coverage
Were your spouse and/or dependent children, if any, covered under another employer's group plan? ☐ Yes ☐ No
If so, please provide:
Name of previous employer | Name of insurer | Date of termination of coverage Y Y Y Y M M D D

2. Are you actively at work and capable of performing each and every duty of your employment?
☐ Yes ☐ No
If not, please provide a brief explanation

Important: If this section is not completed, Standard Life will process this form on the assumption that you are actively at work and capable of performing each and every duty of your employment.

Participant statement - information on persons to be insured (Complete only for persons to be insured)

☐ **Participant** — Height ☐ ft.in. ☐ m — Weight ☐ lb ☐ kg — Sex ☐ M ☐ F

Place of birth | Date of birth Y Y Y Y M M D D

Number of years in Canada (if place of birth is outside the country)

Occupation

Main residence address (no., street) | Apt.

City | Province | Postal code

Telephone no. (day) | Telephone no. (evening)

☐ **Spouse** — Height ☐ ft.in. ☐ m — Weight ☐ lb ☐ kg — Sex ☐ M ☐ F

Surname or maiden name (if different)

Given name(s)

Place of birth | Date of birth Y Y Y Y M M D D

Number of years in Canada (if place of birth is outside the country)

Occupation | Telephone no. (day)

☐ **Children**

Surname and given name(s) | Sex ☐ M ☐ F
Height ☐ m ☐ ft.in. | Weight ☐ lb ☐ kg | Date of birth Y Y Y Y M M D D

Surname and given name(s) | Sex ☐ M ☐ F
Height ☐ m ☐ ft.in. | Weight ☐ lb ☐ kg | Date of birth Y Y Y Y M M D D

Surname and given name(s) | Sex ☐ M ☐ F
Height ☐ m ☐ ft.in. | Weight ☐ lb ☐ kg | Date of birth Y Y Y Y M M D D

Surname and given name(s) | Sex ☐ M ☐ F
Height ☐ m ☒ ft.in. | Weight ☐ lb ☐ kg | Date of birth Y Y Y Y M M D D

Surname and given name(s) | Sex ☐ M ☐ F
Height ☐ m ☐ ft.in. | Weight ☐ lb ☐ kg | Date of birth Y Y Y Y M M D D

Surname and given name(s) | Sex ☐ M ☐ F
Height ☐ m ☐ ft.in. | Weight ☐ lb ☐ kg | Date of birth Y Y Y Y M M D D

Authorization to provide information

Standard Life

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. ('MIB') or other organization, institution or person, that has any records, knowledge or information about me, my spouse or my dependents concerning our health and insurability, to provide such information to The Standard Life Assurance Company of Canada or its reinsurers, in order to evaluate my eligibility and insurability or that of my spouse and my dependents, if any, under this plan. I agree that an investigation report regarding myself, my spouse and my dependents may be requested.
I authorize The Standard Life Assurance Company of Canada, or its reinsurers, to make a brief report of my personal health information to MIB.
A photocopy of this authorization shall be as valid as the original.

Participant signature (if to be insured) | Date Y Y Y Y M M D D

Spouse signature (if to be insured) | Children over 18 signature (if to be insured)

Important: Please complete and sign both sides of this form.

Notice concerning MIB Inc. (Medical Information Bureau)

You must detach and keep this notice.

Information regarding your insurability will be treated as confidential. The Standard Life Assurance Company of Canada or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is:

330 University Avenue, Suite 501
Toronto, Ontario, M5G 1R7
Telephone: 416-597-0590

The Standard Life Assurance Company of Canada, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at **www.mib.com**.

Participant statement - medical questionnaire

Have any of the persons to be insured (including your spouse and children, if any)	Participant		Spouse/ Children	
	Yes	No	Yes	No
1. had cancer, a tumor, diabetes, a heart, circulatory or blood disorder, or high blood pressure?	☐	☐	☐	☐
2. had a nervous disorder, a liver, lung or kidney disorder, an ulcer or an intestinal disorder, or any urine abnormality?	☐	☐	☐	☐
3. had arthritis, rheumatism, a disorder of the bones or joints, or backaches?	☐	☐	☐	☐
4. developed AIDS or an AIDS-related complex, or had a positive result from a test designed to reveal the presence of the virus that causes these diseases?	☐	☐	☐	☐
5. been absent from work for 10 days or more due to illness or injury in the past two years?	☐	☐	☐	☐
6. submitted to an electrocardiogram, an X-Ray (excluding dental X-Rays), a blood test or any other test for diagnostic purposes, or been advised to do so in the past five years?	☐	☐	☐	☐
7. used drugs without a physician's prescription, been advised to make a more moderate use of alcohol, or been treated for drug or alcohol abuse?	☐	☐	☐	☐
8. had an application for life or health insurance declined, rated or postponed?	☐	☐	☐	☐
9. been examined by a physician or received treatment in a hospital, clinic or sanatorium in the last five years, for any reason other than those mentioned above?	☐	☐	☐	☐
10. have a physical abnormality or deformity?	☐	☐	☐	☐
11. been following a diet, receiving medical care or treatment?	☐	☐	☐	☐
12. been expecting to receive medical treatment or to undergo an operation in the next twelve months?	☐	☐	☐	☐
13. presently taking any medication?	☐	☐	☐	☐
14. smoked cigarettes, small cigars (cigarillos), a pipe or used smoking cessation aid products during the past twelve months?[1]	☐	☐	☐	☐

[1] Standard Life must be advised of any change in smoking status.

If you answered "Yes" to any of the questions above, please provide details in the space below.

Question no.	Given name	Illness, injury, condition or reason	Tests, operations, treatments and results	Medication brand name(s)	Date of annual exam	Onset of illness/injury	Date of complete recovery	Full name and address of physicians and hospitals
					YYYY MM DD	YYYY MM DD	YYYY MM DD	Name Address Telephone no.
					YYYY MM DD	YYYY MM DD	YYYY MM DD	Name Address Telephone no.
					YYYY MM DD	YYYY MM DD	YYYY MM DD	Name Address Telephone no.
					YYYY MM DD	YYYY MM DD	YYYY MM DD	Name Address Telephone no.

Please date and sign any document(s) submitted with this form.

Statement

I, the undersigned, hereby certify that the statements made in this document and in any document attached hereto are complete and true.

I authorize the employer, the policyholder, the plan administrator, The Standard Life Assurance Company of Canada or their reinsurers, their respective agents and mandataries to give, receive and share any personal information in order to evaluate my eligibility and my insurability or that of my spouse and children, if any, under this plan.

I understand that coverage will only take effect when my application is accepted by the insurer.

I have read the notice on the reverse concerning the exchange of information with MIB (Medical Information Bureau) and other insurers.

I understand that my social insurance number may be used as my certificate number within my group plan, and that it is my responsibility to advise my plan administrator if I do not wish my social insurance number to be used to identify me under the group plan.

Participant signature (if to be insured)	Date Y Y Y Y M M D D
Spouse signature (if to be insured)	Children over 18 signature (if to be insured)

Important: Please complete and sign both sides of this form.
Note: An incomplete questionnaire will delay processing of the application for insurance.

www.standardlife.ca

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